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ABSTRACT

This report is designed to: (1) synthesize information presented at a forum on adolescent fertility in Sub-Saharan Africa and to review the major research findings; (2) provide highlights of some notable program efforts reaching adolescents in Sub-Saharan Africa; and (3) offer a series of recommendations for future action. Five key cultural and social factors that affect adolescent fertility in Sub-Saharan Africa were identified: (1) rapid rural-to-urban migration; (2) increasing educational attainment for women and rising ages in marriages; (3) breakdown of traditional value systems; (4) the continuing influence and adaptation of certain traditional factors; and (5) the spread of HIV/AIDS. High rates of adolescent pregnancy in Africa are related to two factors: (1) high rates of sexual activity among teens, both married and unmarried; and (2) extremely low use of contraception. One of the strongest programmatic responses to these issues has been the implementation of Family Life Education (FLE) curricula in African schools. Additional programs are identified and discussed. Ten specific recommendations are made, including conducting operations research to identify successful programs and expanding AIDS prevention for youth. Lists of co-sponsoring organizations and participants at the International Forum on Adolescent Fertility are included. (DB)

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ADOLESCENT FERTILITY IN SUB-SAHARA AFRICA

STRATEGIES FOR A NEW GENERATION

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BASED ON THE PROCEEDINGS OF THE INTERNATIONAL FORUM ON ADOLESCENT FERTILITY

THE CENTER FOR POPULATION OPTIONS
INTERNATIONAL CENTER ON ADOLESCENT FERTILITY

Special Note

This publication was developed from the International Forum on Adolescent Fertility, held in Arlington, Virginia, USA, September 1990, and also provides background information for the First Inter-Africa Conference on Adolescent Health, held in Nairobi, Kenya, March 1992.

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Other Publications in This Series:

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- Funding the Future: A List of Agencies With an Interest in Supporting Adolescent Health

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International Center on Adolescent Fertility (ICAF)

ICAF is the international project of the Center for Population Options (CPO), a nonprofit organization based in Washington, DC, USA. CPO seeks to develop a consensus that too-early childbearing and the spread of HIV and other STDs among adolescents must be viewed as high priority problems having major implications for individuals' and societies' well-being. CPO works to enhance opportunities for young people in key decision-making areas of their lives: continuing their education, planning their families, obtaining needed health and social services, and attaining productive employment.

ICAF supports youth programs in developing countries by:

- Offering seed grants and technical assistance to help groups in Africa and Latin America initiate effective projects;
- Working with professionals and leaders of international family planning, population, youth service, development and women's organizations to focus attention on adolescent reproductive health issues;
- Conducting assessments of program and policy developments which ICAF communicates through presentations at professional meetings and in professional journals;
- Helping policy leaders, the media and the public better understand the implications of too-early childbearing and the spread of AIDS and other STDs among adolescents;
- Collecting and disseminating program information and resources;
- Developing curricula, program guides and other practical tools for use by programs;
- Conducting trainings in developing countries in **Life Planning Education** and **Como planear mi vida**, CPO's widely acclaimed youth development program, and other topics related to adolescent reproductive health;
- Publishing **Passages**, a quarterly newsletter available in English, French and Spanish.

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I. INTRODUCTION

The mission of the International Forum on Adolescent Fertility held in Arlington, Virginia, USA, in September 1990 was to call together a select group of experts from around the world to discuss the current state of affairs regarding adolescent fertility in developing countries. Recalling the First Interhemispheric Conference on Adolescent Fertility in 1976, participants concluded that we have made only modest progress since then — and have far to go — in providing for adolescent reproductive health needs and lowering teen pregnancy rates. The Forum addressed, "What have we done?" and "What can we do?"

In exploring these topics, participants discussed three specific themes: (1) Adolescent Reproductive Health Rights in the Developing World, with a focus on the impact of unsafe abortion, (2) Adolescent Fertility in Sub-Saharan Africa and (3) Funding Adolescent Fertility Programs in Developing Countries.

Sub-Saharan Africa was given special importance as a region due to high rates of early and often unintended pregnancies and because of growing interest in the issue on the part of policymakers and service providers. Indeed, the past 10 years have seen a tremendous amount of research on adolescent fertility in Africa and the implementation of a variety of program models to prevent early and unwanted pregnancies.

Participants at the International Forum on Adolescent Fertility. Pictured in the first row from left to right are: Joseph Karueru of the Family Planning Association of Kenya; Dr. Adepeju Olukoye of the University of Lagos Teaching Hospital in Nigeria; Valentino Lema, the Director of CSH.

However, results from the recent Demographic and Health Surveys (DHS) presented at the Forum clearly demonstrated that in spite of improved access and use of family planning in parts of Sub-Saharan Africa, unwanted pregnancies to adolescents continue to be an issue of major social and demographic importance. In 11 countries representing 40 percent of the population of Sub-Saharan Africa, births to adolescents ages 15-19 comprise between 15 percent and 20 percent of all births. In 10 of the 11 countries, the majority of teenage women will give birth by age 20. The sheer numbers of births to adolescent mothers are equally daunting: in Nigeria, 905,000 births to adolescents occur annually, while in less populous Kenya some 200,000 births to adolescents occur each year.

In addition to the formal presentations at the Forum, excerpts of which are incorporated into this document, a small group of individuals from Kenya, Nigeria, Cameroon, and Sierra Leone met to discuss the possibility of forging regional strategies to address adolescent reproductive health issues. One of the foremost obstacles to making a real impact on teen pregnancy rates, the group concluded, was the lack of communication and collaboration on the part of individuals and organizations who are fighting similar battles to provide adolescents with the informa-

tion and services they need. As a first step toward better collaboration, the group proposed the formation of a continent-wide network on adolescent health and a regional meeting on adolescent health to be held in Africa.

With this informal discussion, the "First Inter-African Conference on Adolescent Health: Present and Future" was born. The goals of the conference are ambitious:

- To improve networking and linkages among individuals and organizations working in adolescent health in Africa;
- To forge long-range strategies on an individual country basis and regional basis to expand the provision of health and reproductive health information and services to adolescents;
- To promote a positive change in attitudes on the part of policymakers and the general public that will allow for realistic efforts to address the issues; and
- To promote the exchange of ideas regarding what works in the African context to provide needed information and services in health and reproductive health to youth.

The organizations which planned the conference — led by the Centre for the Study of Adolescence, the Centre for African Family Studies, and the National Council on Population and Development in Nairobi and the Center for Population Options in Washington — were motivated by a conviction that much more must be done to reach adolescents with adequate reproductive health information and services. The existing data has clearly pointed to the impact and extent of too-early childbearing in Africa. An impressive number of programs — ranging from family life education, to peer counseling, to family planning services for youth — have been implemented in many parts of Africa. Educational attainment for women and average age at marriage — both precursors of lower adolescent fertility rates — have increased substantially in many African countries. Yet recent data tells us that the issue of teen pregnancy in Africa is not going away, and indeed in a few countries, has actually gotten worse. Thus, the questions we must answer are: "Why?" and "What can we do next?"

The purpose of this publication is to: (1) synthesize information presented at the International Forum on Adolescent Fertility along with a review of major research findings; (2) provide highlights of some notable program efforts reaching adolescents in Sub-Saharan Africa; and (3) provide a series of recommendations for future action on a topic that is of vital importance for millions of African youth — and indeed the health and well-being of the continent as a whole.

As Nafis Sadik, Executive Director of the United Nations Population Fund (UNFPA), pointed out in the opening plenary of the Center for Population Options' conference that followed the International Forum, adolescent fertility worldwide continues to be a roadblock to girls' and women's educational achievement, their status and their full participation in society. She concluded, in a presentation that has become UNFPA's official statement on adolescent fertility, that these issues need the urgent attention of all parts of society because, in her words, "our future lies in the hands of youth." (See Box 5, Section V for the text of her remarks.)

II. THE CULTURAL AND SOCIAL CONTEXT OF EARLY CHILDBEARING IN SUB-SAHARAN AFRICA

Adolescent fertility in Sub-Saharan Africa is not a topic that can be isolated and examined as a simple social construct. It is a complex issue that stands with one leg firmly rooted in longstanding African traditions of early marriage and high rates of childbearing and one leg stepping into a rapidly modernizing and urbanizing world. Early childbearing in Africa is by no means a new phenomenon; what is new and changing is the context in which it is occurring.

Before examining the extent and implications of adolescent fertility in Africa, it is important to underscore this social and cultural context. There are, broadly speaking, five key cultural and social factors that profoundly affect adolescent fertility in Sub-Saharan Africa. Some of these factors are lingering traditions; others are social forces that are dramatically changing the Africa in which today's young people live.

1. **Rapid Rural-to-Urban Migration.** Sub-Saharan Africa is urbanizing at rates higher than any other region in the world. In 1965, 13 percent of the population of the region lived in cities; by 1984, 25 percent of the population lived in cities and by 1990 the United Nations estimated that nearly 35 percent of the population of Sub-Saharan Africa had become urban. Between 1960 and 1984, Africa's cities grew by 6 percent per year. In 1960, Sub-Saharan Africa had only three cities with populations of 500,000 or more. By 1980, it had 27.(1) A large portion of this urban migration consists of youth. The United Nations estimates that 47 percent of African youth ages 15-24 will live in urban areas by the year 2000, compared to 41 percent of the total African population of all ages.(2)

2. **Increasing Educational Attainment for Women and Rising Ages at Marriage.** While young Africans have been moving to cities, they have also been enrolling in school in rapidly increasing numbers and proportions. As Table 1 demonstrates, between 1960 and 1983 the number of primary and secondary students in Africa quintupled from less than 13 million to 63 million. The number of African children and youth enrolled in school increased by 9 percent annually during the 1970s, double the rate of growth in Asia and triple the rate of Latin America. In spite of high population growth during the same period, gross enrollment ratios rose from 36 percent in 1960 to 75 percent in 1983.(3)

Table 1: Enrollment of Females in Sub-Saharan Africa as Proportion of Total Enrollment

	1960	1983
Primary		
Total Enrollment (millions)	11.9	51.3
Gross Enrollment Rate	36%	75%
Percent Female	34%	44%
Secondary		
Total Enrollment (millions)	00.8	11.1
Gross Enrollment Rate	03%	20%
Percent Female	25%	34%

Key:

Percent Female: Percentage of total enrollment who were female.

Gross Enrollment rate: Percentage of school-age children enrolled in school. The figure sometimes overstates the proportion enrolled since children older than the typical age for their grade are also included in the enrollment figures.

Source:

Education in Sub-Saharan Africa: Policies for Adjustment Revitalization and Expansion, World Bank, Washington, D.C., 1988.

The cultural and societal impact of this revolution in education is only beginning to be understood. In real terms it has meant that the average educational attainment of working age women and men in the median African country increased from less than one-half a year in

The number of students enrolled in school in Africa increased from 13 million in 1963 to 63 million in 1983. The impact of this change only is beginning to be understood and has tremendous ramifications for adolescent fertility.

1960 to three years in early 1989. At the same time, the adult literacy rate in the median African country rose from nine percent to 42 percent.(4)

For young women, the impact has been especially important. The proportion of females as a percent of the total enrolled population increased from 34 percent of the primary school population in 1960 to 44 percent in 1983. Similarly, at the secondary level, young women comprised 25 percent of students in 1960 compared to 34 percent in 1983.(5) Perhaps even more dramatic was the fundamental shift in parts of Africa from the prevailing attitude that women should remain in the home to one that encouraged women to seek education.

Where did this tremendous demand for education come from? A recent World Bank report highlights the source: "... the economic changes that the colonial powers set in motion in Africa helped create a demand for western-style education that, in many areas, seemed insatiable. Education became the vehicle for moving, within one generation, from peasantry and poverty to the topmost ranks of society. This fact of modern-day life escaped few African parents looking for ways to promote a better future for their children."(6)

Unfortunately, economic stagnation in the 1980s slowed and eventually eroded gains in school enrollment. The peak occurred in 1983-84 when 16 African countries achieved the milestone of 80 percent primary school enrollment and continent-wide primary school enrollment reached 84 percent. As of 1990, however, this had fallen to 70 percent.(7)

Largely as a result of increased school enrollment, another key factor in early childbearing has been changing dramatically over the past 20 years: age at first marriage. While the trend toward increasing ages at marriage is mixed in Africa — with some countries showing an increase while others show it staying the same or decreasing — the overall tendency seems to be toward increasing average ages at first marriage. In Kenya, for example, data from the Demographic and Health Surveys shows that the age at first marriage for women ages 20-24 is 19.8 years compared to 18.6 for women ages 25-29. Similarly, in Uganda, the average age at marriage for women ages 20-24 is 18.6 compared to 18.3 for women ages 25-29. In Togo, the figures are 19.5 and 19.2, respectively. In some countries, however, including Liberia, Mali, Cameroon, Cote d'Ivoire, and Lesotho, there is no evidence of any increase in age at first marriage in the past five years.(8)

Whether this trend in increasing age at first marriage will continue on a regional basis is unclear. The United Nations, for example, in a recent report is pessimistic that gains in education enrollment will continue, due to current economic conditions in Africa; without increasing female enrollment, age at marriage may remain relatively constant.(9)

These two trends — increasing enrollment for girls and rising ages at first marriage — along with lowering average ages at menarche have combined to create what some have called a "bio-social gap." This gap, which has been widely written on, is the lengthening period of time between menarche, when childbearing often started in many traditional African settings, and the age at marriage. A recent World Bank study on the issue argued

that the recent surge of interest in adolescent fertility in Africa is rooted in the emergence of adolescence as a stage of life — created by this "bio-social gap" — particularly among the growing number of urban young people attending secondary school.(10)

3. **Breakdown of Traditional Value Systems.** One of the chief casualties of rapid rural-urban migration in Africa is the demise or weakening of many traditional, tribal value systems. In traditional, more rural Africa, early childbearing was often encouraged and nearly always took place within marriage or consensual union. In addition, many traditional African societies have rites of passage, age-prescribed initiation ceremonies or other cultural practices that served — and in some cases still serve — as mechanisms for the transmission of information and values about family life, child spacing or family planning and sexuality. Many early studies on sexuality in Africa indicate that among some tribal groups premarital relations were common and sexual freedom was a fact of life from early ages as long as pregnancies were avoided — and as long as the activity took place within the watchful eye of the tribal village.(11) In other tribal groups, premarital sexual relations were considered taboo and social mechanisms were set up to enforce this norm. In either case, a tribal system clearly communicated its values to youth and provided them with the necessary information to adhere to the prescribed norms. Some examples:

- In most tribal groups in Kenya, boys and girls were initiated into a socially recognized "age set" or "age grade" system with males moving through clearly defined roles of youth, warrior, and elder with roughly equivalent, though not as clearly marked, roles for women. Initiation rites taught that premarital sex was permitted if precautions were taken, such as avoiding penetration, so that pregnancy did not occur.(12)

- In Sierra Leone, "secret societies" with ritualistic creeds and codes prepare boys and girls for their future adult roles. Initiation was, and in many cases still is, a prerequisite for marriage. Even with urbanization and modernization, the societies are still considered strong. They have adapted to changing times by lowering the age of initiation from between 15 and 18 years to between 9 and 12 and shortening the time of the initiation rites from a few months to a few weeks. "Grannies" or elder women who run the female secret societies strongly discourage premarital sexual relations, and perpetuate female genital mutilation as one means to achieve this.(13)

- In Botswana, pre-colonial tribal groups strongly discouraged premarital sex through a combination of age-regimented initiation ceremonies and heavy penalties for boys and girls if girls did not remain chaste until marriage.(14)

However, modernization and rapid urbanization have left youth spatially and psychologically cut off from elders who were traditionally responsible for conveying information related to sexuality. In the absence of these traditional systems, African youth face a dearth of accurate information on sexuality and family life. No adequate new system has sprung up to replace the old one. The result: African youth report that they turn to their equally misinformed peers as the primary source of information on sexuality, as the results of recent focus group discussions with youth in Kenya and Nigeria presented in Box 1 highlight. Others have hypothesized that premarital sexual activity has increased among African youth as a result of the decline in traditional values, as Robert Leke of Cameroon points out in Box 2.

A recent sample survey from Kenya helps to confirm the conclusion that African youth are turning to their peers for information. A 1989 study of 3316 youth ages 12-19 both in and out of school found that the main sources of information on issues related to sexuality were school, friends and same sex relatives, in that order. For females, 41 percent reported that

Box 1: Focus Group Findings from Nigeria and Kenya

[Results of focus group discussions in Mombasa, Kenya, and Zaria, Gabari, and Ibadan, Nigeria, with both in-school and out-of-school youth. The information was gathered as background for the International Forum.]

For the majority of youth in all three focus group sites, discussing sexuality with adults was relatively difficult and awkward, and a novel experience. The majority of youth interviewed in both countries had not received a formal sex education course – with the exception of the youth in Kenya who were involved in a sex education program run by the Family Planning Association of Kenya. Others said they had received some information on reproduction in biology class, but nothing about sexuality or family planning.

Many of the youth said that it was impossible or uncomfortable for them to talk about sexuality with their parents or other family members. For the majority, the sources of information were: (1) peers, and (2) adult movies and magazines, in that order. Some teens were extremely uncomfortable discussing such issues, while others were curious and had many questions that they had not had the opportunity to ask before.

For some youth in northern Nigeria, the lack of information was extreme. In the case of young married females in Gabari (a semi-rural village in predominantly Muslim northern Nigeria), for example, all but one were married before menarche and the majority said they had received no information about their bodies or the reproductive process prior to getting married. They said that no one had told them about menstruation, and hence they thought they had a disease. One girl who was still living in her parents' home when she started her menses was told about menstruation by her mother; another girl was told about menstruation at Islamic school. However, the majority of the young women asked their mothers-in-law, their grandmothers-in-law or husbands what was happening to them -- only after they started menstruating.

These responses reflect a widely held belief in Hausa culture which says that a girl should already be married and living in her husband's house at the time of the first menses. In this way, the girl will be safely guarded in her husband's compound when she is able to conceive. The lack of information given to these young women may be another means of discouraging them from experimenting sexually.

In more urban and westernized Zaria, also in the northern, predominantly Muslim part of Nigeria, in-school, secondary school-age youth said they got information about sexuality from popular "adult" magazines as well as love novels. Young men in Zaria also mentioned adult movies as a major source of information; one boy perceived these as negative influences saying they cause young people to do things that they would not normally do.

Both males and females in Zaria said they were taught about human reproduction in biology class, but said the information was not practical and did not describe how to prevent pregnancy. As one young woman said: "There is no information about 'the safe period.'"

When asked with whom they felt the most comfortable discussing matters relating to sexuality, Zaria males and females said their peers. Some of the boys said they talked to their elder brothers, but for all, talking to parents, grandparents or aunts and uncles was a taboo.

Similarly, in Ibadan, in southern Nigeria, in-school youth said they received scant information about reproduction in biology class. Hence, most said they discussed puberty and its physical changes only with friends. One young man in secondary school said: "It is easier discussing it (sex) with young people because the older people want to know where you first heard about it and from whom. They shut us up and say that we want to start doing 'ishekuse' (bad things) before growing up."

Source: *"Peer Interaction and Traditional and Modern Influences on Adolescent Sexuality in Nigeria and Kenya: Findings from Recent Focus Group Discussions," Gary Barker and Susan Rich, Center for Population Options and Population Crisis Committee, Washington, DC, 1991.*

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they got their information from school, 23 percent from friends, 10 percent from female relatives and 7 percent from their mother. For males, 38 percent reported school as their primary source of information, 27 percent friends, and 11 percent printed materials outside of school (e.g. adult magazines). For out-of-school youth — whom it must be remembered represent the majority of Kenyan youth surveyed — the majority relied on friends. Very few youth relied on the traditional sources: elders, "aunties" or grandparents as once was previous practiced in much of Kenya.(15)

4. **The Continuing Influence and Adaptation of Certain Traditional Factors.** While many traditional cultural influences in Africa have weakened, others have remained strong or adapted to changing times. In parts of Africa, for example, early marriage continues to be practiced, largely as a way of preventing out-of-wedlock pregnancies. In one state in predominantly Muslim northern Nigeria, for example, 30,000 girls complete primary school each year, but government schools can only accommodate 3,000 in secondary schools. Those girls who are forced to discontinue their studies usually marry soon after and begin their childbearing — some as young as 12 and 13.(16)

   Similarly, female genital mutilation, which has been practiced on an estimated 100 million African women and girls in more than 26 countries in the region, is rooted in a complex set of customs regarding hygiene, aesthetics, rites of passage, religion and a desire to control women's sexuality. In many areas, female genital mutilation provides a way to ensure women's virginity and thus maintain patrilineaty and prevent premarital and out-of-wedlock pregnancies.(17) Like early marriage, female genital mutilation is intended to prevent the scandal of out-of-wedlock pregnancies. It also has reinforced notions of women as property or of female sexuality as a potentially dangerous force that must be controlled.

Box 2: The Social Context of Adolescent Fertility in Cameroon

[Excerpted from a presentation at the International Forum on Adolescent Fertility]

Professor Robert Lekeu
University of Cameroon

The rural exodus of young men and women to urban areas and the passing away of the older generation has led to a disappearance of the traditional sociological support system for youth. In its wake, traditional education has been killed and youth are now being exposed to new adventurous activities like sex, for which they are psychologically and emotionally unprepared.

Thus, the adolescent begins to explore his or her new environment and learns (about sexuality) from radio, TV and peers. The information obtained is often inadequate, leading in turn to unplanned pregnancies. In general, modern society offers less security and social responsibility to the adolescent than traditional African society. The tendency in modern society is toward looser interpersonal relationships and bonds. Modern education alone has not filled the gap left by the passing of traditional Africa society. Without other social functions, education on its own creates an emptiness and this is sometimes filled by precocious sexual activity. The results of this situation are well-known: dismissal from schools, embarrassment and disappointment of parents, clandestine abortions, and sometimes even divorce due to secondary infertility.**Gross Enrollment Rate**: Percentage of school-age children enrolled in school. The figure sometimes overstates the proportion enrolled since children older than the typical age for their grade are also included in the enrollment figures.

Source:

Education in Sub-Saharan Africa: Policies for Adjustment, Revitalization and Expansion, World Bank, Washington, D.C., 1988.

Another set of practices — that combine both traditional and modern influences — present in Africa are those related to "sexual networking", mistresses, polygyny with younger women and "sugar daddies." Numerous studies have mentioned the issue of girls initiating sexual activity with older men and often in exchange for material gain; others have pointed to a population of urban young women who have a series of long-term sexual relationships with men in exchange for money or housing.(18) The concept of "sugar daddies" — older men who offer favors in return for sex — is found in studies in the early 1950s reporting girls who turned to these men to earn money to pay for their school fees and is virtually identical to findings from recent focus group discussions with youth in Nigeria.(19) A number of programs also report that school teachers are known to harass students, seeking sexual relations in return for better grades. One study on adolescent fertility says that older men may be more frequently responsible for early pregnancies than young men.(20)

One of the casualties of rapid rural-to-urban migration in Africa is the demise or weakening of many tradition, tribal value systems. These rural children and youth in Nigeria are far more likely to receive information from traditional sources than are their urban counterparts.

In parts of Africa where polygyny is still practiced, men frequently take younger wives. With the spread of AIDS and STDs in some areas, it has been reported that men are turning to even younger women because they are seen as "clean" or free of STDs. In one part of Nigeria it is reported that the cure for STDs is having sexual relations with a virgin.(21)

The Christian traditions of the colonial powers also brought their influence to Africa, introducing or reinforcing a deep-seated adult discomfort with discussing adolescent sexuality and strong moralistic taboos associated with premarital sexuality. This taboo of discussing sexuality outside of the traditional initiation rites has been mentioned as a factor in nearly all parts of Africa. In some cases, this taboo has been a major obstacle to implementing family life education or sex education. This adult discomfort is also at the root of laws and policies prohibiting the distribution of family planning information or methods to unmarried adolescents.

These attitudes are associated with a widespread view in contemporary Africa that premarital pregnancies must be punished as socially deviant behavior.(22) One result of this attitude is the nearly universal policy in Sub-Saharan Africa that pregnant girls are expelled from school and prohibited from returning. (It is not universal, however, that the boys responsible for the pregnancies are forced to drop out.)

This combination of weakening cultural influences, lingering traditions and the modern influences of sexual permissiveness, peer pressure and new taboos has created a confusing situation for African youth. Some individuals have advocated making a clear distinction between those traditional practices which are harmful, and those which are positive, as Olayinka Koso-Thomas explains in Box 3, and using these traditional networks to transmit more "current" information. Whatever the case, African youth are in many ways freer than ever and have more time to experiment sexually, but they do not have the guidance that once existed to prevent socially undesirable consequences.

5. **The Spread of HIV/AIDS:** No current discussion of the social context of adolescent reproductive health in Sub-Saharan Africa would be complete without mentioning HIV/AIDS. Indeed, with the rapid spread of AIDS in pockets of Sub-Saharan Africa — where it is estimated to affect between one-fifth and one-quarter of the adult population — there are signs that attitudes toward sexuality may be changing.

   There is an acute shortage of data on how AIDS is affecting adolescents in Africa. At a global level, the World Health Organization estimates that 20 percent of persons with AIDS are in their twenties which, given the latency period of the virus, means that many of those contracted the disease while in their teens. The WHO also estimates that one out of 20 adolescents contracts a sexually transmitted disease (STD) each year.(23) In parts of Africa, where gonorrhea is estimated to affect between 10 percent and 20 percent of the sexually active population, STD prevalence for adolescents may be even higher than the worldwide rates. Indeed, scattered data on STDs other than HIV/AIDS -- a risk factor highly correlated with spread of HIV/AIDS -- shows that they are at high risk, as does limited data on HIV among African youth:

   - In Kenya, a 1990 study found unspecified STDs in 36 percent of youth ages 15-24 visiting Kenyatta National Hospital in Nairobi.(24)

Box 3: Traditional Practices in Sierra Leone

[Excerpted from a presentation at the International Forum on Adolescent Fertility]

Olayinka Koso-Thomas
Sierra Leone National Committee
on Traditional Practices Affecting
the Health of Women and Children in Africa

There is ample evidence in the medical literature that certain traditional practices are harmful. Adolescent women have had to endure their share of the harmful effects of these practices -- some of which stay with them for the rest of their lives. It has been repeatedly recommended that many of the practices be reviewed so that only those with positive values be retained. Non-governmental organizations and government ministries should voice concern for the present situation.

Adolescent women and men should be given better education about fertility issues. The information gap, where it exists, should be narrowed and the misinformation of the youth quickly and effectively removed. The following steps should be part of a specific plan for Sierra Leone:

- Production and broadcast in all local languages concentrating on known problems associated with harmful traditional practices;
- Research with adolescents to find out what they know and don't know about sex education to improve the content of family life education (FLE);
- Establishment of clinics where sexually active youth can receive contraceptive advice and services;
- Extension of sex education and FLE to reach non-literate adolescents using non-formal teaching methods;
- Find ways to enable leaders of the Secret Societies and community elders to benefit from improved education about harmful traditional practices and make necessary changes within the existing traditional structure;
- Raise the minimum age of marriage to 18.

But no matter how much is done to relieve the various problems associated with harmful traditional practices, success will elude us unless a massive campaign is mounted for the eradication of illiteracy.

- Unspecified STD rates among university students in Sierra Leone were found to be 16 percent in 1982.(25)
- In Nigeria, a 1983 study of asymptomatic female college students found that 24 percent had gonorrhea.(26)
- In Blantyre, Malawi, Lusaka, Zambia, and Kigali, Rwanda, recent studies of pregnant women show rates of HIV-seropositivity between 22 percent and 30 percent. Given that births to adolescent women comprise up to 20 percent of all births in many parts of Sub-Saharan Africa, many of these young mothers who are HIV-positive are likely to be adolescents.(27)
- In Uganda, the Ministry of Health reports that of the estimated 800,000 Ugandans thought to be HIV-positive as of 1990, there were twice as many women in the 15-25 age range as young men. This is due, they claim, to the fact that females are becoming sexually active at younger ages than males.(28)

A few available studies also show high rates of misinformation on the part of youth, as well as of high-risk behavior. In Zimbabwe, for example, a 1989 study of 1532 secondary students found that 40 percent thought HIV could be contracted from toilet seats and 40 percent believed that most persons with AIDS in Africa were homosexual. In addition, 16 percent of males reported sexual relations with a prostitute.(29)

In countries such as Uganda where the number of AIDS cases are doubling every six months, concern over the disease may eventually prompt more frank discussions of sexuality and more condom promotion, even among unmarried teens. The deadly spread of AIDS — as tragic as it is — may have one small benefit: it may ultimately be a key factor that forces changes in attitudes regarding adolescent sexuality and adolescent fertility by forcing policymakers, parents and other concerned adults to provide more accurate information on sexuality and more access to reproductive health services including condoms.

III. THE EXTENT AND IMPACT OF EARLY CHILDBEARING IN SUB-SAHARA AFRICA

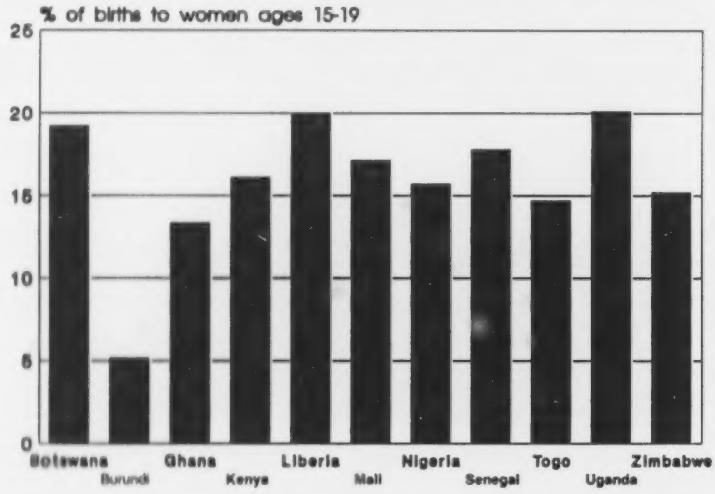
The cultural and social factors described above have directly affected the situation of adolescent fertility in Sub-Saharan Africa, where early childbearing rates are among the highest in the world. On average more than 50 percent of African women have given birth by age 20, and in some African countries, as many as 40 percent of women have their first child before age 18.(30) Given that 31 percent of Africa's population was between the ages of 10 and 24 in 1990, births to adolescent mothers have tremendous social and demographic impact. As Table 2 shows, births to adolescents currently represent between 15 and 20 percent of all births for 11 African countries for which current data are available.

High rates of adolescent pregnancy in Africa are directly related to two factors: (1) high rates of sexual activity among teens, both married and unmarried, and (2) extremely low use of contraceptives. As the following section describes, this lack of access to contraceptives has led in turn to a high reliance on unsafe, illegal abortion as a means of preventing unwanted births and has also led to a number of other negative consequences associated with early childbearing.

1. **Sexual Activity:** Sexual intercourse before age 20 is fairly common even among unmarried African adolescents. In data from the Demographic and Health Surveys (DHS), more than half of teenage women ages 15-19 in seven of 11 countries had sexual relations at least one once; in Kenya, Liberia, Togo, Ghana and Botswana more than half of the young women with sexual experience were not married.(31) According to World Fertility Survey (WFS) data, unmarried adolescents in Sub-Saharan Africa are more likely to be sexually experienced than their counterparts in Latin America and Asia, with levels of sexual activity roughly equal to or less than youth in Europe and North America.(32) It is interesting to note that in studies from Nigeria and Kenya, a high percentage of teens reported negative attitudes toward premarital sexual activity, while at the same time a large number of youth were sexually active. This probably reflects their own discomfort with an issue about which they have received little guidance and the mixed messages they have received from their parents, peers and society.

2. **Contraceptive Use:** Contraceptive use, low for women of all ages in Sub-Saharan Africa, is even lower for adolescents. WFS data from the early 1980s shows that among married teens, contraceptive use ranged from a high of 13 percent in Ghana to a low of one percent in Benin and Nigeria.(33) Similarly, from more recent DHS data, contraceptive use among currently married teens ranges from more than 25 percent in

Table 2: Births to Adolescents as Proportion of Total Births, Various Countries



Source: "Adolescent Women in Sub-Saharan Africa: A Chartbook on Marriage and Childbearing," Demographic and Health Surveys and Population Reference Bureau, Washington, DC, 1992 (draft).

Zimbabwe to 1 percent in Nigeria. For unmarried adolescents, DHS data shows that contraceptive use ranges from 25 percent in Botswana to less than 5 percent in Kenya. While contraceptive use increases with age and educational status among African young women, it is still very low.(34) Some other data:

- In Nigeria, a study of 489 female post-secondary students found that while two-thirds had knowledge of family planning, only 23.3 percent of those who were sexually active had ever used contraception.(35)

Adolescent women in Sub-Saharan Africa face a number of negative social consequences as a result of their pregnancies. Perhaps first and foremost is being forced to drop out of school. In 1988, an estimated 8,000 teenage girls were forced to drop out of school in Kenya because of pregnancies.

- In Kenya, a study of 3,316 youth ages 12-19 both in school and out of school found that while 50 percent surveyed reported having had sexual relations, only 11 percent reported ever having used contraception. For educated females ages 16-19, the rate of contraceptive use was nearly four times the average of all the other groups. The chief reasons cited for not using contraception: lack of knowledge followed by difficulty in obtaining them.(36)

- In Kampala, Uganda, a 1988 survey of 1133 adolescents ages 15-24 both in-school and out-of-school found that by age 17, 30 percent of the women had one or more pregnancies and 23 percent of those who had been pregnant had had at least one abortion.

Two-thirds of those who were sexually active were not using any contraceptive method. The main reasons they cited for not using contraception: contraceptives were unsafe, objections by male partner, and insufficient knowledge.(37)

As these examples point out, one of the chief barriers to higher contraceptive use by teens is lack of access. For the various cultural reasons cited above, there is a strong ambivalence and in many cases even resistance on the part of governments, parents and service providers in Africa in promoting contraception among unmarried youth. In some countries this reluctance has been turned into a ban or limit on adolescent access to contraception. The Family Planning Association of Kenya, for example, has had to fight significant political battles to be able to provide family planning services to adolescents.

A recent United Nations inquiry on population issues found that 12 of 18 Sub-Saharan African countries that responded to the survey said they provided contraceptives to unmarried teens, implying that the other one-third do not. In addition, only 22 percent of the countries who responded to the same survey said that contraceptive eduction was included in the public school curriculum.(38) In a survey of programs working in teen pregnancy prevention in Latin America, Asia and Africa, African programs reported the lowest rate of contraceptive provision to unmarried youth.(39)

3. **Unsafe, Illegal Abortion**: Low use and availability of contraceptives combined with high rates of unintended pregnancies has led to a high reliance on abortion on the part of adolescent women in Africa. DHS data for unmarried women from eight countries found that between 50 percent and 75 percent of first pregnancies for five of the eight countries were reported as unintended.(40)

Ironically, the very factors promoting lower teen pregnancy rates — increased education and higher ages at marriage — are forcing more African young women to rely on unsafe abortion as a way of controlling their fertility. As a recent World Bank study says: "... it appears that substantial proportions of these (African female) students are sexually active and that their rates of pregnancy are relatively high. Moreover, the difficulty of combining schooling and child-bearing appears to have led to a heavy reliance on potentially illegal abortions."(41)

III. THE EXTENT AND IMPACT OF EARLY CHILDBEARING IN SUB-SAHARA AFRICA

As Table 3 shows, a review of data from 13 studies in seven Sub-Saharan African countries found that adolescents (roughly in the 11-19 age range) represented between 39 percent and 72 percent of all women presenting with abortion-related complications, including septic or incomplete abortions, in a number of major African hospitals.

A recent study by the Center for Population Options concludes that adolescents are more likely to seek abortions from a nonmedical provider, more likely to seek abortions later in their pregnancies, and slower to seek medical help if complications develop. These delays in turn lead to higher rates of complications, more expensive medical treatment, and longer hospital stays. Complications of unsafe abortion include hemorrhage, septicemia, anemia, cervical and vaginal lacerations, pelvic abscess, perforation of the uterus or bowels, tetanus,

Table 3: Adolescent Women Presenting at African Hospitals with Abortion-Related Complications 1974-91

COUNTRY	SAMPLE SIZE	PERCENT YOUTH	SOURCE (YEAR)
Cameroon (Yaounde)	*	38.6% (11-19)**	Leke, 1989
Kenya (Nairobi)	610	Mean age 19.8	Aggarwal, 1982
Kenya (Rural)	1077	53% (under age 24)	Lema, Kamau, Rogo, 1989
Kenya (Nairobi)	36,622	67% (of deaths were to women 10-25)	Wangala, 1985 (1974-1983)
Mali (national)	1031	43% (15-19)	Burton, 1985
Nigeria (Ilorin)	852	66.7% (11-19)	Adetoro, 1986
Nigeria (8 states)	#	55% (under 20)	Okagbue, 1990
Nigeria (Benin)	1418	60.8%("adolescent girls")	Omu, 1981
Nigeria (Calabar)	147	72% (13-19)	Archibong,1991
Sierra Leone (Freetown)	560(1)	81% (15-24)	Stiles, 1982
Zaire (Kinshasa, Matadi, Bukavu)	2465(2)	57.5% (under 18)	Bongwele, 1986
Zambia (Lusaka)	200(3)	59% (under 25)	Chatterjee,1985

Key:
Sample Size: Number of women presenting with complications from induced abortion (unless otherwise noted).
Percent Youth: Percent of the sample consisting of youth; age range in parentheses.
** All emergency hospital admissions at principal maternity hospital.*
*** Percent of those who needed treatment for two or more days.*
 # Data from eight hospitals with between 40 and 150 cases from each hospital.
Notes:
(1) Total number of women admitted for treatment of spontaneous or induced abortion or seeking an abortion; 81 percent of those seeking treatment for complications related to induced abortion were ages 15-24.
(2) Total number of cases represents women admitted with abortion complications, 25 percent of which were categorized as induced; 57.5 percent of the women under age 18 arrived because of complications of induced abortion.
(3) Sample consisted of 200 women requesting induced abortion; of those, 59 percent were under age 25.
Sources: See Notes.

secondary sterility, and in some cases death. These complications, in addition to the personal cost to the young women, further strain poorly equipped hospitals and tight public health budgets. (For more information on the topic of adolescents and abortion, see the related publication in this series: *Adolescents and Unsafe Abortion in Developing Countries: A Preventable Tragedy*, available from the Center for Population Options.)

4. **Social Consequences**: In addition to unsafe abortion, adolescent women face a number of negative social consequences as a result of their pregnancies. First and foremost is the issue of being forced to drop out of school. A 1988 study in Kenya found that an estimated 8,000 teenage girls were forced to drop out of school that year because of pregnancy-related reasons.(42) Similarly, in Tanzania, a 1984 study by the Ministry of Education found that 18,766 primary and secondary school students were expelled from school due to pregnancy in 1982.(43)

   A recent study from Rwanda highlighted other side effects. In a study of 510 unmarried women, the majority of whom were or had been teenage mothers and had at least one child, one-fourth of the women said they were subjected to "moral persecution" and 10 percent said they were disowned by their families. In 50 percent of the cases, the father did not acknowledge the child.(44) The issues of child abandonment or "baby dumping" as well as the high number of young women forced to work in prostitution in major African cities to support children they bore while adolescents have also been cited as social consequences of teen pregnancy.

   Unfortunately, there is a lack of data showing the direct costs to African governments of high numbers of young women dropping out of school due to pregnancy. If such costs were calculated on a country basis, it could provide valuable evidence to show the urgent need for information and services.

5. **Medical Consequences**: The medical consequences of early childbearing both on the mother and the child have been well-documented by the WHO and others. Women under age 20 suffer more pregnancy and delivery complications, such as toxemia, anemia, premature delivery, prolonged labor, cervical trauma, and death, than do women who have children at age 20 or later. In 10 sub-Saharan African countries, WFS data found that the proportion of babies dying within the first month of life was 50 percent higher and post-neonatal mortality was 25 percent higher when the mother was under age 20.(45) DHS data confirmed this finding that infant mortality to children born to adolescent mothers is higher than for women ages 20-29. The rate of infant mortality was above 110/1000 for six of 11 countries for women 15-19 but only above 110 in two countries for women ages 20-29.(46) Another medical effect of early childbearing is vesicovaginal fistula (VVF), the chief cause of which is prolonged labor, along with small pelvic size associated with very young mothers and cuts made by traditional birth attendants in some regions. A recent study from northern Nigeria found that nearly 60 percent of 241 recent VVF cases were to women under age 18, and 27 percent were women under age 15.(47)

   The medical and social consequences of early childbearing in Africa have been well-documented, as is apparent by the significant amount of literature on the topic. What is needed now is a discussion of program approaches to deal with teen pregnancy in Sub-Saharan Africa.

IV. PROGRAM RESPONSES

In the past 10 years, there has been a widespread recognition on the part of policymakers and service providers of the information gap left regarding sexuality and family life among adolescents due to cultural and societal changes in Africa. Schools, followed by church groups, youth groups and health organizations including family planning organizations were called in to fill the gap. The most common response has been the development and implementation of "family life education" (FLE) curricula — training that combines sexuality education with information on family roles and family life. In Kenya, for example, various forms of FLE have been carried out with youth for more than 20 years.(48) In Sierra Leone, the government implemented one of the first nationally established FLE programs, implementing it throughout the primary and secondary school system. The program was hindered chiefly by the small portion of the school-age population actually enrolled in school.(49)

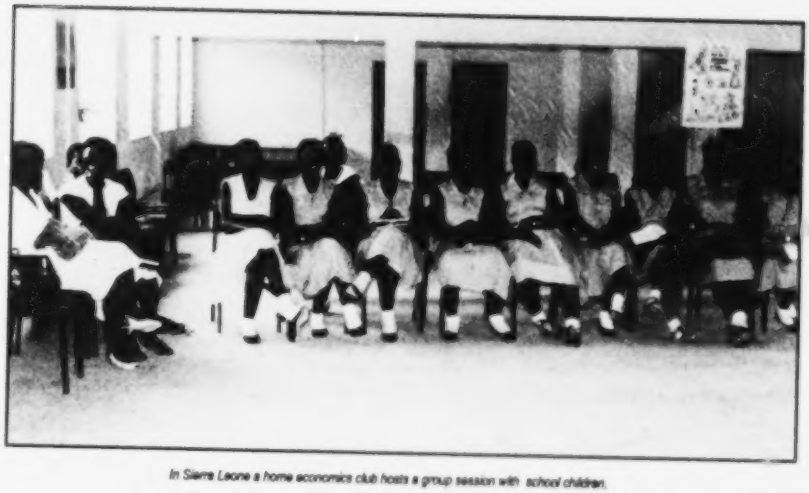
In spite of the widespread interest and implementation of FLE curricula in Africa, there have been a number of questions about the quality of the information provided. Some youth-serving organizations have charged that FLE is frequently overloaded with population education, which while important, is sometimes substituted for information on sexuality and family planning. Others have questioned how effective teachers — who are generally relied on to present FLE — are in presenting material which they themselves probably feel uncomfortable discussing.

A common response to the issue of adolescent pregnancies in Africa has been the development of family life education (FLE). In Kenya, forms of FLE have been promoted by governmental and private groups for more than 20 years. Here peer counselors and their supervisors are pictured with the Family Planning Association of Kenya in Mombasa.

Indeed, some survey data underlines these questions. A recent study from Kenya found that while 65.5 percent of youth ages 12-19 said they have received some information on reproductive health (many in school), less than 8 percent could correctly identify a woman's fertile period.(50)

In addition to FLE, a number of other program approaches have been implemented in Africa in the past 10 years with the goal of preventing teen pregnancies, some of which are listed in Box 4. The following examples from Nigeria, Sierra Leone, Tanzania and Ethiopia highlight innovative approaches that have gone beyond FLE to provide family planning services and peer counseling to youth.

These important initial efforts, along with others too numerous to include here, are already pointing the way to effective program models for wider implementation. What is needed now is more evaluation and operations research to determine which program models are truly successful and appropriate and have the strongest potential for replication or adaptation.



In Sierra Leone a home economics club hosts a group session with school children.

Box 4: Program Approaches in Adolescent Pregnancy Prevention in Sub-Sahara Africa

Family Life Education: FLE, which incorporates elements of sex education with family life information, has been widely implemented in Sub-Saharan Africa through school systems, church groups, youth-serving organizations such as the Boy Scouts, or through National Youth Corps, with both in-school and out-of-school youth.

Incorporating Reproductive Health into University Health Centers: Given high drop-out rates due to pregnancy in many African universities, a number of university health centers have started family planning services and sex education through the university health program.

Support Centers for Teen Mothers: On a limited basis, a number of programs have been started to assist teen mothers by offering education, vocational training, day care, medical services, sex education and family planning to prevent repeat pregnancies.

Peer Education and Peer Distribution of Non-Medical Contraceptives: Both for out-of-school and in-school youth, such programs take advantage of existing informal channels of information and train young people to be counselors in issues related to sexuality, AIDS prevention and family planning for their peers. Some programs also include distribution of condoms and other non-medical contraceptives.

Information, Education and Communication Programs: Either incorporated into other programs or developed on their own, IEC programs in Africa have included drama programs for youth and feature films, such as the film "Consequences", music videos and records on issues related to early childbearing.

Source: ICAF, with information from a presentation by Nelson Keyonzo, Pathfinder International, Nairobi, Kenya, at the International Forum.

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Multi-Dimensional Approach to Adolescent Fertility Management (MUDAFEM)

Peer Education on a University Campus

Ibadan, Nigeria

Launched by the Fertility Research Unit, a branch of the Department of Obstetrics and Gynecology at the University College Hospital, Ibadan, Nigeria, MUDAFEM provides counseling on sexuality and family planning, peer distribution of non-medical contraceptives, and clinic-based family planning services at the University of Ibadan, home to more than 10,000 students.

The program was started in 1988 when a group of medical students, concerned about the death of a fellow medical student from a self-induced abortion, approached the Fertility Research Unit to request services for students in reproductive health. Through a pre-test on knowledge, attitudes and practices of the students with regard to family planning and sexuality, MUDAFEM found that a majority of students were sexually active and that two-thirds had had more than two sexual partners in the past three years. In addition, the pre-test revealed that 7 percent reported having had an STD at least once, 22 percent reported that they or one of their partners had been pregnant, and 84 percent of those said the pregnancy had resulted in abortion.

These findings were combined with results of focus group discussions with students (in which program planners decided to use the peer education approach) to set the criteria for the recruitment of peer educators, design promotional materials, and design a curriculum for training. Five student educators and 75 peer promoters, primarily nursing and medical students, were selected and participated in a basic training in sex education and family planning methods. These designated "MUDAFEM promoters" were assigned to five dormitories for the pilot phase of the project. The promoters were given reference materials, as well as a small kit with t-shirts, posters, and a supply of condoms and foaming vaginal tablets. Each educator placed a poster or sticker on his or her door saying, "Prevent the Preventable, See Your Hall Peer Promoter Today." Following the training, the promoters conducted a day-long awareness-raising campaign, including parades through campus and distribution of handbills.

Once the peer educators were trained and the program was implemented, contraceptive commodities were resupplied monthly as necessary during meetings; these meetings also provided an opportunity for the educators to meet and exchange experiences and to ask questions of the coordinators or nurses from the Fertility Research Unit. Students requesting a permanent contraceptive method or other medical attention were referred to the university health service or to the Fertility Research Unit.

Over the course of the six-month pilot project, educator retention was high; only one student educator dropped out during initial pilot period because her parents opposed her participation. The educators were paid a modest stipend as an incentive and to cover out-of-pocket expenses.

An average of 2,200 male students and 450 female students requested condoms each month from the peer educators. In the second phase of the program, which involves expansion of the program from the original five pilot dorms to 12 dorms on campus using 360 promoters, program coordinators will use a systematic pre-test and post-test to attempt to quantify any change in awareness produced by the peer program.

Sierra Leone Home Economics Association

Peer Education to Out-of-School Youth

Sierra Leone

In 1986, the Sierra Leone Home Economics Association (SLHEA) started a Youth-to-Youth Peer Education Project for out-of-school youth in rural and urban areas in Sierra Leone. The main objective of the project is to promote responsible sexual behavior and positive youth development through peer counseling and education, peer distribution of non-medical contraceptives, referrals for family planning and health services, and cultural, recreational and income generation projects.

SLHEA has trained 200 out-of-school youth leaders, ages 18 to 25, who were recruited from youth clubs and organizations, including social clubs, religious clubs, Boy Scouts, Girl Guides, football clubs, YWCA, YMCA, Red Cross and others. Training focuses on preparing the peer leaders to provide information and counseling to their out-of-school peers on sexuality and family planning issues. Brochures, leaflets and booklets on relevant topics were developed for a youth audience; youth also participated in the design of the materials. Each trained youth leader is equipped with a set of project materials to use in counseling sessions. Emphasis is placed on identifying sexually active youth who need information and family planning services. The peer counselors refer clients who require more information to the project office or a family planning clinic.

After a positive response from youth, SLHEA began distribution of non-medical contraceptives (condoms and foaming vaginal tables) through the peer leaders. As an incentive, peer educators sell the contraceptives for a modest price and kept a portion of proceeds as a stipend. More recently, some of the youth clubs participating in the project have turned to income generation projects such as gardening and soap-making to provide sources of long-term support for the program.

UMATI Dar es Salaam Youth Center

Education and Vocational Training for Adolescent Mothers

Dar es Salaam, Tanzania

The UMATI Dar Es Salaam Youth Centre was founded in 1986 to assist teen mothers and pregnant adolescents who are forced to drop out of school due to unplanned pregnancy. The program is modeled after a program first implemented by the Women's Centre in Jamaica. The program offers an integrated range of services including academic instructions, counseling, vocational training, family life education, day care services, family planning and health services.

The primary goals of the project are to allow teen mothers to reduce the likelihood of a repeat, unplanned pregnancy. The project also seeks to influence policies that force young women to leave school due to pregnancy. The inability to complete their formal education seriously compromises the social and economic well-being of these young women.

UMATI Youth Centre is also registered as an Adult Education Centre and is authorized to examine students for the award of primary school equivalency certificates, a significant achievement. During its first year, the program assisted 17 teen mothers, 7 of whom successfully passed the Standard 7 primary school equivalency exam for admission to secondary school. This passing rate is almost four times the rate of Tanzanian primary school students. In its third year, the program was expanded to include 46 mothers, 18 of whom were successful in gaining places in secondary schools.

Four days a week, the teen mothers receive training in academic subjects, including math, English, Kiswahili, social studies, family life education and nation-building. One day a week, the young women receive health care and individual counselling. The project also provides vocational skill training , including needlework and cookery. Students actively have participated in income generating efforts through preparation and sales of snacks and tailoring.

According to Center staff, project success include: (1) increased awareness of the policy level of adolescent fertility issues; (2) increased participation of young fathers and the parents of the teen mothers; (3) increased community support for and interest in the program. Project staff cite absenteeism and attrition as obstacles. A number of repeat pregnancies, four in the first year, were noted due to pressure from parents and young fathers to leave the Centre and incorrect use of contraception. The length of stay for the teen mothers was extended from one year to two years in an attempt to overcome some of these problems. While UMATI has not yet been successful in convincing the government to change its policy of expelling school girls, policy support for initiatives such as these is increasing.(51)

Family Guidance Association of Ethiopia

Reaching In-School Youth

Addis Ababa, Ethiopia

The Family Guidance Association of Ethiopia, the Ethiopian affiliate of the International Planned Parenthood Federation, has been providing family planning and maternal and child health services since 1966. Three years ago, FGAE began to implement an adolescent reproductive health project in Addis Ababa, involving counseling services for youth and informal outreach through peer education.

FGAE's approach has been through schools where it has introduced sex education classes and has gained wide support of both teachers and parents. The approach includes forming students' clubs in the school; the clubs then provide informal opportunities to discuss issues related to reproductive health. In addition to the youth-to-youth segment of the program, older teens serve as counselors and provide referrals for sexually active youth. Condoms and vaginal foaming tablets are distributed through FGAE youth centers and youth are referred to FGAE clinics.

More recently, FGAE organized a drama club to produce and stage educational plays with messages on unwanted pregnancies, sexuality and family education. The presentations are lively and designed by youth themselves. The drama club charges for its presentations, and thus is able to recover some money for its expenses.(52)

V. CONCLUSIONS AND RECOMMENDATIONS

The extent and impact of adolescent fertility in Sub-Saharan Africa has been well-documented over the past 10 years. What is missing now is wider and concerted action to address the issues, however complicated and politically sensitive they may be. The following recommendations emerged from the International Forum on Adolescent Fertility. A series of recommendations from Nafis Sadik of the United Nations Population Fund are also included in Box 5.

In addition to consulting experts for their recommendations at the International Forum, staff from the Center for Population Options and Population Crisis Committee also met directly with youth in Kenya and Nigeria for their recommendations on how to better meet their reproductive health needs. Their suggestions are found in Box 6.

1. **Conduct Operations Research to Identify Successful Programs.** Programs working in adolescent reproductive health are fairly new in Africa; most are less than 10 years old. Nonetheless, there are a number of innovative and apparently successful programs in existence. Operations research could strengthen these programs and point to potential models for replication by identifying successful program elements.

2. **Increase Advocacy Efforts Regarding Adolescent Fertility in Sub-Saharan Africa.** Given the politically sensitive nature of the issue and the barriers involved, local programs and researchers must form coalitions to advocate on behalf of increased reproductive health services for youth. Such advocacy efforts could be strengthened by research showing the cost to African governments of school expulsion of pregnant schoolgirls or the cost to health ministries from abortion complications to adolescents.

3 **Improve the Content and Delivery of Family Life Education Programs.** Given the heavy reliance on FLE as a source of information for African youth and the shortcomings expressed, efforts should be initiated to improve FLE on a continent-wide basis. This could entail increasing the amount of information on family planning contained in FLE, adding such issues as decision-making and self-esteem, and improving the skills of the teachers who are relied upon to present the material.

4. **Increase Efforts to Reach Out-of-School Youth.** Given that nearly half of African youth do not complete primary school, and that only about a third actually go on to complete secondary school, efforts must be increased to reach out-of-school youth. While such programs are often costly and difficult to implement, they are nonetheless urgently needed. In most cases, out-of-school youth are at higher risk of early pregnancies and the spread of STDs including AIDS.

5. **Improve and Create New Mechanisms for Networking on Adolescent Reproductive Health in Africa.** Given communication difficulties in Africa, service providers and researchers often work in isolation rather than joining forces. With the establishment of new networks, such as an African Association for the Promotion of Adolescent Health, health professionals from throughout the continent can combine their efforts and learn from their combined experience to improve the level of services for youth.

6. **Increase the Provision of Family Planning Services to Married and Unmarried Youth.** As recent data shows, access to family planing services is extremely low for adolescents, both married and unmarried, even lower than it is for adult women in Africa. Without increasing the level of family planning services to this population, adolescent women in Africa will continue to rely on unsafe and illegal abortion as a means of dealing with unintended pregnancies.

7. **Increase Efforts to Abolish Harmful Traditional Practices and Other Policies Detrimental to Youth.** Closely affiliated with early childbearing are a number of harmful traditional practices — principally early childhood marriage and female genital mutilation. In addition to the devastating personal costs to millions of African women, these practices perpetuate sex-role stereotypes that deny adult and adolescent women in Africa of the power to control their own bodies and lives. The policy of forced expulsion of pregnant school-girls should also be abolished.

8. **Increase Funding from International Donors and National Governments for Adolescent Reproductive Health.** Given the proportion of births to adolescents as a total of all births in Africa, international donors and African governments alike have no choice but to pay attention to the needs of adolescents if they are serious about improving family planning services.

9. **Expand AIDS Prevention for Youth.** Given the ages of sexual initiation in much of Africa and the rapid spread of HIV, youth must be a larger part of overall AIDS prevention efforts in Africa. This should include better research on knowledge, attitudes, practice and epidemiology of HIV/AIDS among youth.

10. **Support the Individuals Who Are Fighting on Behalf of Adolescents.** As Bayo Akintobi, speaking as the youth representative at the International Forum said: "One of the most important facts of development is individual commitment. We need people wiling to stick their necks out (for adolescents)."

It is clear that African youth, in the absence of traditional sources of information, face an urgent information gap. It is also apparent that the forces are in place — rising ages at marriage and increased educational attainment for women — to lessen the desire for early childbearing. Unfortunately, there is also an acute lack of family planning services to both married and unmarried adolescents. This unmet need for family planning has in turn led to a heavy reliance on abortion among African adolescents.

The final message from African youth themselves is that safe or unsafe, accurate or not, they are finding the reproductive health services and information they seek. They turn to misinformed peers for information and they frequently rely largely on untrained service providers for unsafe abortions. The message to governments and service providers is equally clear: pay now for sex education and family planning services for youth, or pay later in terms of school drop-out rates and hospital costs associated with abortion complications. Certainly the future of Africa — its youth — deserve much more.

The extent and impact of adolescent fertility in Sub-Saharan Africa has been well-documented over the past 10 years. What is missing now is wider and concerted action to address the issues, however complicated and politically sensitive they may be. Certainly the future of Africa—represented by its youth—deserves much more.

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Box 5: The Global Impact of Too-Early Childbearing

[Excerpted from her keynote presentation at the Center for Population Options' 10th Anniversary Conference, "Remembering Youth: Building Healthy Options for Our Future," which followed the International Forum on Adolescent Fertility]

Dr. Nafis Sadik
Executive Director
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As a social and economic issue, adolescent fertility generally is a roadblock to girls and women's educational achievement, to their status, and to their full participation in the community. It narrows their life options. In many societies, girls are valued and treated as second-rate citizens. They are much more likely to die in infancy than boys, they are less likely to go to school, and they tend to leave school earlier. Women derive their status more from motherhood than from anything else they do. Most women in developing countries spend practically all of their fertile years engaged in pregnancy and infant and child care, and they do so because they have no other options and because their future is determined by others.

[Among Dr. Sadik's recommendations:]

- **Invest in Women.** Real efforts should be made to offer girls and women education and training which go beyond basic literacy. Like many things, timing is of critical importance (particularly) timing of marriage, as well as the first birth and subsequent births. Programs which advocate delaying marriage and childbirth in favor of eduction have a special place.
- **The Need for Education.** [There is a] lack of knowledge among young people of reproductive health issues, sexuality and the responsibilities of parenthood. Most of the time, the information they acquire from their peers or on the streets, or even from their families, is both misleading and unhelpful. Education systems -- both formal and non-formal -- must be encouraged and enabled to provide young people with accurate information and education.
- **The Need for Research.** Even if young people have the knowledge, it does not necessarily mean that they will be motivated to act. Much remains to be done to research and understand the social-psychological factors affecting young people's attitudes and behavior. We should also reach out to adolescents with carefully researched and thoroughly pre-tested messages that are framed in a language they can understand using channels that are credible to them.
- **Recognize that Youth are not Homogenous.** In reality, the needs of nulliparous young woman are a world of difference from those of a multiparous women. The situation of unmarried youth is very different from that of the married. Communicators must, therefore, target appropriate messages to carefully segmented audiences.

(continued on page 23)

Box 5: The Global Impact of Too-Early Childbearing (cont'd)

- **Improve Social Services and Health Systems for Youth.** The service system should be responsive to young people's needs. Health workers should have an empathy for young people as well as a capacity to listen. They must be trained to communicate effectively with young people.
- **Pay Special Attention to the Needs of Unmarried Youth.** With the high incidence of out-of-wedlock adolescent pregnancies in many countries, the special needs of the unmarried deserve more attention. In societies that do not condone such pregnancies, unwanted pregnancies are often terminated by abortion, legal or not. Adequate provision of family planning services would help prevent abortion.
- **Address the AIDS Pandemic by Educating Youth.** Sexually transmitted diseases and AIDS are increasingly becoming problems that threaten not only the future of today's young people, but also generations to come. Young people's experimentation with sex and drugs could place them at great risk of contracting HIV. Short of a cure of this terrible pandemic, our main weapon remains education.
- **Pay Special Attention to the Role of Men.** It is often the partner who creates obstacles for contraception. Males should, therefore, be educated about their role in family responsibilities, including family planning and childrearing. Boys should be given special attention at a time when their attitudes are still in a formative stage. They should learn to respect other people, including girls and women, and to be responsible for their actions.
- **Involve Young People Themselves.** We should empower them to make informed decisions and choices concerning all aspects of their lives. Young people are not only consumers and recipients of information and services provided by others. We must find ways to galvanize them into action to better themselves as well as society. A very good way to do this is to work together with youth organizations and women's organizations.

Governments, NGOs, the United Nations system and all concerned parties must work together to expand the choices of young people for the new century. Young people must have the freedom of choice that flows from improved status of women and increased access to education, family planning and health care. Self-esteem and reproductive health along with a nurturing early childhood environment and supportive schooling, are essential to enable young people to exercise the options and opportunities that should be theirs. These issues need the urgent attention of all parts of society, for our future lies in the hands of the young.

Box 6: Program Recommendations from Kenyan and Nigerian Youth

[As part of focus group discussions held with youth in Nigeria and Kenya as background for the International Forum on Adolescent Fertility, youth were asked to make recommendations for addressing the issue of early pregnancy and the spread of STDs including AIDS among youth in their communities. The following are their suggestions.]

- Peer promoters with the Family Planning Associate of Kenya highly recommended peer counseling as a way to reach youth saying: "(By working as peer counselors), at least when we become parents, we'll be confident enough to talk to our children about sexuality and family planning."
- Young married women in Gabari, Nigeria, said that all young women should be given information on family planning, menstrual difficulties and STDs. They liked the idea of a peer counseling approach and also thought the counselors should distribute contraceptives in their village. They said: "We would like it and we would like it fast," adding that they do not want to age prematurely with unplanned pregnancies.
- Similarly, young women in Zaria, Nigeria, said that young people should have better information before they are married so they will be well-informed when they marry. When asked how they would like to receive this information, they said the best way for them to learn about sex and reproductive health is to talk with friends or read about it alone and then have a chance to discuss it. Subjects they would like to discuss are: family planning, AIDS and STD prevention.
- Male students in school in Ibadan, Nigeria, said that a good way to educate youth is to use pictures and dramas that show the consequences of misusing one's body. School, homes and neighborhoods were suggested as good places to transmit this education.
- Young women (out-of-school) in Ibadan said that peers, parents, and medical professionals were the best persons to transmit sex education information, which they said could take place in health centers, markets, club houses, family planning centers, meeting places, and cinemas. Some suggested reaching youth through radio, records, cassettes, newsletters, magazines, comics, and novels. There is a serious lack of reliable information in print and from other sources, they noted.
- Out-of-school young men in Ibadan said that the most effective places to reach youth with sex education are where youth naturally gather, including schools, markets, and bus parks. The most preferred source of information, they said, is peers. Sex education, they said, can be taught in schools with home lessons for those not in school. Radio, television and printed booklets are also good ways to reach the out-of-school population, they said. When asked for solutions to the problem of early unwanted pregnancies, they suggested that vocational training opportunities be increased, jobs created, and the educational system enhanced by the government.

Source: "Peer Interaction and Traditional and Modern Influences on Adolescent Sexuality in Nigeria and Kenya: Findings from Recent Focus Group Discussions," Gary Barker and Susan Rich, Center for Population Options and Population Crisis Committee, Washington, DC, 1991.

V. CONCLUSIONS AND RECOMMENDATIONS

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VII. CO-SPONSORING ORGANIZATIONS

The following organizations were co-sponsors of the Africa session at the International Forum on Adolescent Fertility:

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The Special Projects Fund of the Population Crisis Committee (PCC) funds innovative projects in the Third World that promise to make a significant contribution to slowing birth-rates. PCC does not conduct its own overseas operations; instead, through the Special Projects Fund (SPF), it supports projects of the many qualified family planning/population organizations that do operate overseas, as long as such projects meet SPF's criteria. The following criteria make Special Projects noteworthy among funding sources for population project is the Third World:

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In the area of adolescent fertility in Africa, PCC has supported, through CPO's Seed Grants Program, the MUDAFEM peer promoter project at the University of Ibadan, Nigeria; the Family Planning Association of Kenya's youth program; CEDPA's Better Life for Young Women project; the Inter-African Conference on Adolescent Health; and the Centre for the Study of Adolescence in Nairobi.

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The program encourages a comprehensive approach that includes: family planning, safe motherhood, child survival and development, and control of sexually transmitted diseases. It also supports efforts to assure the availability of safe and legal abortion. Projects concerned with promoting a better understanding and more open discussion of human sexuality are also supported. Copies of the Foundation's strategy report on Reproductive Health are available from the New York office.

Inquiries should be sent to the Foundation's African offices:

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The United Nations Population Fund (UNFPA)

The United Nations Population Fund (UNFPA) assists developing countries in undertaking population programs and activities. Its primary concern is to assist governments in formulating and implementing population policies and to promote a fuller understanding of the population aspects of development. UNFPA assists governments in designing feasible family planning programs which are appropriate to the particular culture. The Fund supports the provision of all methods of fertility regulation approved by the World Health Organization (WHO) as well as family life education. Of particular interest are efforts to provide information and services to the disadvantaged, especially the rural and urban poor, and newlyweds, men and low parity women.

The Fund provides support for programs and projects in the sectors of family planning; information, education and communication; basic data collection; population policy formulation and development planning; and women, population and development. Training, research, action programs and support communication are the principal types of activities funded. UNFPA focuses on the formulation and implementation of population policies in the context of a country's needs and priorities. Projects promoting institution-building and the training of human resources are of particular value in helping a country achieve self-reliance with regard to population matters. UNFPA has developed a system of independent, in-depth evaluations of activities as well as an internal monitoring system for assessing a project's efficacy.

The Fund continues to support formal and non-formal population education programs and projects — which affect adolescents and youth more than other groups. Other programmatic priorities for adolescents and youth include the strengthening of family life education, communication and, to some extent, family planning. The long-term objectives of these projects are the reduction of the incidence of unintended teenage pregnancy and the promotion of self-reliance and positive responsible behavior among adolescents and youth.

For more information, contact the UNFPA office in your country or:

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